



Reflections: Enriching Ourselves,
Inspiring Others

Indiana University School of Medicine
2005 - 2006



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Note from the Editor

A wise man once told me, “What makes a better physician is whatever makes a better person.” In creating this publication I have come to realize that there are many ways in which individuals enrich their lives. Some do it through art and literature, others through music and recreation. The possibilities are endless and no less fulfilling. The following pages contain poetry, paintings, creative writing, photographs and inspiring thoughts, all originating from members of the Indiana University School of Medicine community, all inspired by their work as healthcare providers. As unique and varied as the creative pieces are within this publication, each and every one served a similar purpose in allowing the author or artist to better themselves, and therefore their work. It is my hope that in reading this you will benefit similarly.

Carla Ralston, '08
With Contributions by Jennifer Wagner, '08

Credits:

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Created July 2005

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Introduction

The ability to “think outside the box” is enhanced by a nurturing culture under which we practice. Unfortunately many people view creativity to be a rare treat or worse, something unattainable and outside the realm of their daily experience. This sad loss represents a missed opportunity to help foster an improvement in self-esteem and denies us an important tool to help one navigate the trials and tribulations that one encounters in life. The arts provide insight into the human condition, suffering, and personhood as well as foster a feeling of our responsibility to each other. Art also offers a historical perspective on medical practice. By paying attention to literature and the arts one can help to develop and nurture the skills of observation, analysis, empathy, and self-reflection. These are humanistic attributes that are essential for humane medical care.

Jeffrey Rothenberg, M.D., M.S.C.

Hope

Lisa Burckhartzmeyer, MSII-Class of 2008

Indiana University School of Medicine– Indianapolis



When all is wrong with the world and school is overwhelming, I can always find *Hope* hanging on my living room wall. The painting of this little girl that I've never met always calms my soul as she reminds me why I'm in this crazy world called medical school. In her longing eyes I find reassurance that I am on this journey for a reason...I am called to be a healer and to take care of children in need. So, I continue on in hopes of making a difference in a child's life through the art and science of medicine. Even in the darkest hours, *Hope* prevails!

Excerpt from 2005 Senior Banquet

*Margaret Gaffney, M.D., Associate Professor of Clinical Medicine
Competency Director for Moral Reasoning & Ethical Judgment
Indiana University School of Medicine-Indianapolis*

So, our patients tell us stories - which we call histories, and we tell each other our patients' stories - which we call consultation or conference. And finally, we tell ourselves these stories back, with an interpretation - perhaps a diagnosis, a treatment plan.

These stories are accompanied by any one or more emotions and values (which we usually ignore, at the risk of our healing values). Sometimes - satisfaction at being correct, at knowing, at being helpful; Sometimes regret - for being unable to know or help. Anger - at our own impotence or ignorance, or at an obstreperous patient. And occasionally gratitude - for the trust given, and forgiveness we experience.

We tell and receive these stories, in order to make sense of our experience, to perceive the meaning in our lives and work.

I was a new junior student on call as an extern at St. Francis Hospital ER (in those days, we did not have a required selective in ER, and it was considered especially helpful if one could land such a position). I had gone to bed, about 2am. ER staff called and told me there was an RHC on the 4th floor - go up and do it. I was sleepy, uncertain. What is an RHC? Heavy sigh - somebody died, respirations have ceased - go up and pronounce. Wide awake now - umm, what do I do?

The physician realized my inexperience and kindly outlined the steps, then said don't worry too much, the nurses are pretty good at this. So up I went and into a dark single room -

tiny wizened man in bed, sheet to chin, frail arms exposed; single light at head of bed. I was so nervous - started as I usually do with a formal introduction (just in case...)

And then, a rustle from the dark corner, and a tiny elderly woman emerged from the shadow, blanket around her shoulder. I gasped, she said, "Oh, my dear, is he all right?"

I was pretty sure he wasn't but was unprepared to speak so soon to his wife. So I shook my head, and took her hand and asked if she would mind waiting with the nurse for a few moments while I examined him (couldn't bear to do it in front of her).

She nodded, and passing, patted his arm, and then mine, as if in comfort and said, "He's been sick for so long..." smiled, left.

I pulled myself together, went through the exam. The nurses were right, but I thought there should be something other than this silence to mark the passing of a man.

Out to the nurse - called the attending who declined to come in and said I could tell his wife the patient was dead. So I found her sitting in the dark lounge, alone, looking at the night lights through the picture windows. I sat down next to her with no idea of what to say, but she made it easy.

"He's gone, isn't he?" I nodded, she teared, and so did I. I asked if there was someone to call and she said her son was on the way. She said, "We were married 50 years." I didn't know what I was supposed to do, but I knew what I could NOT do - I could not leave her, so I listened in the dark as this woman, no longer a stranger, told me the story of their courtship and lives together. There was no way to help, except to listen, and witness. This was the first time I felt the possibility of being a healing presence.

Smoke*

Paul Blusys, M.D.

Clinical Professor of Medicine

Indiana University School of Medicine-Fort Wayne

Today is a sad day for me. Just this morning when I came to work one of the nurses from the outpatient clinic informed me that Pat, one of our patients, had passed away over the weekend. Pat had been receiving IV medication almost daily for the past several months for severe end-stage congestive heart failure. I try to make a point of dropping by the outpatient clinic and saying “hi” to those patients who are here for chronic therapy. I guess Pat and I hit it off well, because we always seemed to have a chuckle whenever we met. She typically had a twinkle in her eye and a mischievous smile on her face, despite being short of breath from her CHF. She would be the first to defend my choice of ties, (generally under scrutiny by the outpatient nurses), so I felt Pat was on my side.

About two weeks ago I asked one of Pat’s nurses where she was and was told that the medication had stopped working and that she would not be coming to the clinic any more. I had missed Pat for the past couple of weeks and will miss her even more now because I will never see her again. The last time we talked, a couple of weeks ago, we had just suffered a couple of cool nights and it seemed like fall was in the air. We talked about that wonderful aroma of burning leaves that is such an unmistakable hallmark of autumn. Pat said that she couldn’t handle being near smoke anymore because it really affected her breathing. But she said she wanted to get a whiff of burning leaves at least once more, because it felt so good.

What is it about burning leaves that smells so good? Does it evoke fond memories of being young, chasing through the piles of leaves our parents piled up that we would scatter everywhere? Do we remember hiding in a pile of leaves playing hide and seek? Maybe it's jumping into huge piles of leaves and doing acrobatics while somewhere in the neighborhood someone is burning their leaves.

I hope Pat got her wish and was able to experience that sweet, smoky, aroma in the autumn of her life. She was a wonderful lady and made a lot of my days a whole lot more fun when we had our visits together in the clinic. Pat was a special person and touched a lot of us in a very special way, and kept smiling until the end. Somewhere, sometime, if I'm real lucky I may get to see Pat again.

**Reprinted with permission from Fort Wayne Medicine Quarterly (2003, Autumn), 1(1), 4.*

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*Anonymous, Class of 1963
Indiana University School of Medicine-Indianapolis*

“Every physician knows that different patients react differently to medications. Some patients are exquisitely sensitive to the least bit of medication, and generally speaking they know beforehand if they are one of those patients. I have learned the hard way to listen to the patients who tell me that they are sensitive to medications. I remember one patient who told me that she was sensitive to morphine as a narcotic.

I believed that based on the type of procedure she was having that morphine would be the best option for her because of its longevity of action. I went ahead and used the morphine

and that was a big mistake. She became very sick as a result of the medication. I immediately regretted having used the morphine and spent a lot of time talking with her. I could not apologize enough and expressed to her how badly I felt after not having truly listened to her. It is important to listen to what your patients have to say. As physicians we may know the science, but the patients know their own bodies.”

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Trichomoniasis

Jeffrey Rothenberg, M.D., M.S.C.

Assistant Professor of Clinical OB/GYN

Indiana University School of Medicine-Indianapolis



*Anonymous, MSIV-Class of 2006
Indiana University School of Medicine-Indianapolis*

“During a month in Honduras, I noticed that a lot of people wait to go to the doctor until they have advanced disease. While in Honduras I saw a lot of disease that I would never have gotten a chance to see in the U.S. The physicians there didn’t have the resources to treat the patients in a way that I was accustomed, yet they managed to give more or less the same standard of care. I really learned not to take the resources I have available here at IU for granted and to work hard to use the available technology to ensure better outcomes.”

.....

Life and Death on the Nyayo Wards

*David Crabb, M.D.
Chairman, Department of Medicine
Indiana University School of Medicine-Indianapolis*

The day begins with the call of the ibises, large birds with curved beaks and an unmistakable cry (which gives it its name, *kwarara*). Sunrise is at 7:00 am every day because we are virtually on the equator. So regular is sunrise and sunset that the Swahili clock begins with 7:00 am as *saa moja asubuhi*, hour one in the morning; 7:00 pm is *saa moja usiko*, hour one in the evening.

July is winter in Kenya; I assume because the sun is at its most northern point on June 21, and thus as low in the northern sky as it gets. It seems that when the sun is at its lowest southern

point in December, that too should be winter, with two summers separating them when the sun is overhead on the vernal and autumnal equinox.

Life at the IU house in Eldoret stirs. Breakfast is on our own and usually a couple of small bananas, toast with Nutella spread, and coffee or tea. Those rounding on the Nyayo rounds leave the house at 8:45 am for the 15 minute walk to the wards. We pass the *askari* (guards) at the gate and exchange greetings we have been practicing in Swahili class: *Hujambo? Sijambo. Habari yako? Nzuri.*

The road is always busy with bicycles, trucks, cars, *matatus*; the walkers and cattle share the paths worn in the red soil of East Africa. We pass the sign for the Moi Teaching and Referral Hospital Mortuary Services (does the conflict of interest committee have a problem with that?) and turn into the side of the hospital complex where the wards are located. There are surgical, obstetric, ophthalmology, and psychiatry wards branching off of the walkway.

With no cold weather, the covered walkways are the equivalent of our halls. The grounds are beautifully landscaped with tropical flowers and trees; we usually see a chameleon on the fence as we reach the end of the walkway, greet the hospital *askari* (*Jambo!*), and turn into the building housing the medicine and pediatric wards. The guards' job is to ensure that the patients have paid their bill before leaving.

It is striking how little we are involved with the patients, beyond our examinations on rounds (although more may go on in the afternoon when the team returns to do procedures and admit new patients). The patients ask no questions, and we spend almost no time explaining what is wrong with them or what we plan to do to help.

The greatest limitation I have is not the reduced access to diagnostic tests, but the inability to take a history myself. One must learn some medical Swahili: *Unakula? Unatapika?* (are you eating, are you vomiting?), *Sema a* (say ah), *Keti* (sit up), *Lala* (lie down), *Pumua* (breathe), *Asante sana* (thank you very much for all I am trying to learn here). At the end of rounds between 12 and 1, we return to the IU House for lunch, and the patients' families visit. After 3 pm is admitting time and the families leave again.

On reflection, the patients with AIDS may have a better outlook than most of the patients with other chronic diseases. HIV is detected mainly through VCT (voluntary counseling and testing), sometimes by visiting a clinic for prenatal care, and a minority are tested by us after admission to the hospital. Those who are positive visit us in the rural health centers or "clinic 49".

I went to the health centers at Turbo and Burnt Forest with Joe Mamlin and John Sidle. Here is where the battle with HIV is being met. We have a simple room with no sink and an exam table. We take a history that includes sociological information (only one or two patients out of 30 seen in two days have electricity or running water; about 20% come from polygamous families; nearly all have had deaths in the family suspected to be from HIV). I examine the patient; we do a small panel of lab tests (VDRL, CD4, full hemogram [CBC], ALT, creatinine) and get a chest x-ray.

If they have pulmonary infiltrates, we begin four drugs for tuberculosis, if it is negative, we give INH prophylaxis, (since perhaps 30% of Kenyans have been exposed to tuberculosis). A week later, they are seen to review the laboratory tests and therapy may begin. We use a three drug regimen (lamivudine, stavudine, and nevirapine) available as a combination pill. Think of it: potential control of the disease and recovery from opportunistic infections

with 2 pills a day. As Joe said to me at the beginning of the clinic: “Keep in mind that all of the people you see today were given up to die before this program was started.”

The great concern at this point is to be sure that all the practitioners in East Africa are using the drugs correctly so that resistance to components of this treatment plan does not develop. The long term concern is this: we have support at present from the President’s Emergency Plan for HIV/AIDS Relief (PEPFAR), via the CDC and USAID to initiate life-long treatment for 30,000 Kenyans with AIDS: what do we say to patient 30,001? Of course, the answer is, we will figure that out as we get close.

It is 6:00 pm, an hour before sunset and dinner. I am still reading about what I saw but did not recognize or know how to treat given the conditions we work in; relearning the fine points of bedside diagnosis, the pathogenesis of tropical diseases, a smattering of Kiswahili, and the history of the people and country. I think we all feel we are making a small contribution to the Kenyan people, but gaining more from the experience than we are giving. The ibises return at the close of the day.

.....

Because It’s Different There...
Reflections and re-reflections on nine weeks in Kenya
Danny Mallon, MSIII-Class of 2007
Indiana University School of Medicine-Indianapolis

Having done it. For all of my anxiety over having a fruitful, enriching, engaging and meaningful experience that I felt in May, I am satisfied with my passive as well as my active experience in Kenya. I saw a culture far different in most respects from my own, made friends who know the world very differently than the

way I do, ate the food, spoke the language, saw the suffering patients, even kind of treated them, learned the real problems, especially is Sirisia, and basically, no, really lived the life of a Kenyan medical student for a few weeks. I did engage – with Tum, Ndiwa, Mange, Martin, and Kamau.

I broke from my shell in the Health Center, allowing myself to talk with patients, smile with mothers, feel them, examine them, take their blood pressure, make guesses and actually do some medicine instead of just learn about medicine. It's been a jump I've needed to make for quite some time, and now I've made it. I know I need lots of practice at it, and because I know I'm not very good at it yet. I need to learn the academic side even more soundly and completely so that I'm not guessing at both sides of medicine until I'm a good clinician.

I did my part for the group, made a good friend in Steff, and accepted the lifestyle – cold showers, little food, few amenities like hot water, snacks, TV, etc., lots of walking and waiting. I tried to experience Kenya, even though I didn't know how I was doing it. But it worked. I lived in Kenya, no more, no less. I have no great universal understanding of the country's history or politics, but I do have some.

I don't know what it's like to be a poor Kenyan, but I've seen it with my own eyes, I've walked where they walk. But it's inevitably different because I've got more comfortable shoes, literally and figuratively. I could and now have removed myself from 100 shillings per day, from no electricity, hot and clean water, and malaria. I'm out of it, but I was in it or near it at least for a little while. I do understand that life and that world better than a magazine article, pictures or movies try to display them. . . . what a day, I'm going home.

I lived in Kenya, no more, no less. I went because medicine is different there. I expected little more than poverty and new friendships as I prepared to go to Kenya, knowing the rest would just be different. For the first few weeks of the trip, all I saw was disparity and I was just in Africa – plopped down in an alien world. Then I began to see past the disparity to the people, what patients go through to get medical care, how farmers in the far reaches of the country live, how healthcare workers do their jobs so far from adequate resources.

As time passed, I was able not just to see, but to know people not as Africans, Kenyans, or classmates, but as friends. I laughed, argued, told long stories, played games, even sang with them. Spending as much time as I did in Kenya charged my sensibilities toward impoverished people, vulnerable patients and friends, both cherished and new.

.....

Thin as the Wing of a Dragonfly

*Burton Webb, Ph.D.
Associate Professor of Physiology and Immunology
Indiana University School of Medicine-Muncie*

Thin as the wing of a dragonfly
Opaque in feel and texture
Lifting seldom
Revealing little
Sounds

Whispers of what lies beyond
Vision
Wandering sensations of
Something that should be
Familiar

But isn't

At times
In peripheral vision or
subsonic waves
the veil moves
And rumors begin

sometimes disturbing
or joyful
believable doubts
always motivating
a renewed
experience of re-entry

Where does reality
Begin
Where spirit ends
Or is there an intersection
On the thin
Invisible
wings of a dragonfly?

Passing*

Deb Litzelman, M.D.

Associate Dean for Medical Education and Curricular Affairs

Indiana University School of Medicine

Impatient for death's coming,
Frantic for stillness.
Please hear my loving whispers.

...so many years ago I looked at my thin, elderly woman cadaver for the first time thinking only of how I should cut, explore...feeling panicky but also privileged to be allowed to take this journey. I saw her as part of my education, not as person ...until well into the year when my cadaver team and I started dissecting her hands. Her hands reminded me of her personhood or perhaps I had survived enough of my first year of medical school to finally see through wider prisms.

...when my mother declared she would donate her body to my medical school, I felt a mixture of honor and shame...honor that this wonderful, woman would yet again think of a way to give to others even after her death. As a fourth grade school teacher for most of her life, it was in her make-up to figure out how to assist students in their learning. As a daughter, I had been bathed in her encouragement and pride...there is no doubt she helped me achieve physicianhood.

Thus, it was also no surprise that she would want to help other medical students achieve their physicianhood. My shame was felt for the long period of time that I had selfishly viewed my cadaver as an education medium and nothing more; shame about the jokes my cadaver team and I made about the little, elderly

woman body...the parts we tossed around not really in disrespect but because we had not matured enough to see her hands, her organs, her nerves, her vessels as someone's mother, someone's teacher....

*from reflective journaling surrounding my mother's death.

.....

Our Fallen Teacher

*Daniel Altman, MSII-Class of 2008
Indiana University School of Medicine-Indianapolis*

I have come to a place
Where the fallen teach
Existence in novel phase

Planned by me long ago
Though with some notice
An indefinite time of arrival

I am a teacher now
Of things I never learned
A model of those who follow

I am assigned a group of six
Eager to display with expertise
All I have to teach

Strikingly effective
My style is modest
Quiet but far from neat

You may come any time
Alone or in a crowd
No need for cold feet

You learn about my life
Without me saying a word
Of how I lived

Take benefit now
For my tenure is short
I have a higher place to be

I have come where the dead
Mingle with the living
And the fallen teach
To the future giving

I am your fallen teacher
I am your cadaver

This poem is dedicated to "Frank the Tank". Thank you, Frank.

*Anonymous, MSII-Class of 2008
Indiana University School of Medicine-South Bend*

“Looking at the cadavers I fully appreciate the meaning of the saying that you cannot take the things you accumulate in life with you after death. It is that indefinable link between the body and the spirit that is important. When that is severed, the important stuff we accumulated in life, what makes us different from everyone else, goes wherever your religion says it will go. We all become equals, masses of muscle, bones, ligaments, nerves, vessels, and organs.”

.....

A Unique Experience with a Cadaver Donor and the Donor's Family

*Ernest Talarico, Jr., Ph.D.
Assistant Professor of Anatomy and Cell Biology
Andrew Prather, MSII-Class of 2008
Indiana University School of Medicine-Northwest*

This story began April 29, 2003, upon the death of Fern from T-cell lymphoma, when she bequeathed her body to anatomical science. She was 87-years-old. Fern was the mother of eight children, six of which survive today. She lived her life for her family and friends, raising her children and working as a nurse until the murder of her husband during a business burglary. She was described by all who knew her as an "indomitable spirit", and as a writer, who delighted in telling her own stories documented in her compilation entitled, "Fun, Friends and Family." However, it was through her gift of one's self, that a unique

story unfolded, when she came to our gross anatomy laboratory in July 2004.

When the students entered the anatomy laboratory, it was with great trepidation and excitement. Only our imaginations could prepare us for the time that we would meet the ones who would teach us about the intricacies of the human body. And so began the process of discovery. We studied this delicate and powerful engineering masterpiece, examining bones, muscles, nerves, organs and glands.

However, when we viewed the inner surface of Fern's skull, we noted large, irregular bony masses unlike any other donor we had observed. Thus, our research project began -----to investigate this strange, but fascinating anomaly. The condition is called *Hyperostosis Frontalis Interna (HFI)*. It is a bony overgrowth of the inner table of the frontal bone, and it almost always spares the midline. In the case of Fern, we immediately noted additional skull bones were involved. When we presented this specimen to an osteologist (i.e., bone expert), he noted that this was the "most extensive" case of *HFI* that he had seen.

In looking through the literature it has become quite clear that *HFI* is at best an incompletely understood condition. It was first observed in an adult male in 100 BC, and until modern times was more commonly found in men. Historically, Morgagni proposed that *HFI* was part of a syndrome that included obesity, diabetes, and virilism, a triad known as Morgagni's Syndrome. Now, *HFI* is almost exclusively observed in postmenopausal women and is independent of Morgagni's Syndrome. The exact etiology is unknown, as are the clinical manifestations of the condition. Most cases do not have clinical presentation and are only discovered by accident through imaging of the skull

or at autopsy. However, some individuals present with headache, lower back pain, motor deficits and sometimes neuropsychoses in association with *HFI*.

In our attempts to learn more about *HFI*, we decided to learn more about the donor's medical history. In the course of obtaining this history, we were allowed to contact the family of the donor. Little did we know at the time that this would be the first time that a medical student and a professor of the IUSM would be in contact with members of a cadaver donor's family, nor did we know that we would soon be sitting in their living room hearing stories from her life. This meeting took place one day in June 2005. When we arrived at the house to meet with the family, a woman stepped outside to greet us. As we sat in the van, one of us mentioned (AP) that the woman looked very familiar. After one awkward minute of *déjà vu*, we discovered that the woman was a teacher at Medical student Prather's high school and had also been involved in theatrical productions with his father. Immediately the awkward feelings lifted and it became clear that we were in a safe environment with familiar people.

We did not know Fern during her life, but we had the privilege of learning from her body – a legacy of knowledge that will bring others life through our work as physicians and educators. On that day when we met Fern's family, we spent a good deal of the afternoon over a meal that they had prepared for us, interviewing her children and listening to stories about their mother, who selflessly donated her body to our medical education. Ultimately, only a few minutes of our time with the family profoundly affected the content of our research. Fern was no longer just our research subject, but she was transformed into a

human being with a beautiful family altering our motivation for the entire project. Fern's gifts to us, and the participation and enthusiasm of her family, has renewed in us our dedication and desire to lean all we can to help those that we serve through education, research and clinical medicine.

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A Day in the Life

Burton Webb, Ph.D.
Associate Professor of Physiology and Immunology
Indiana University School of Medicine-Muncie

Coffee
Deepest Black
Oozing essential essence that
Dilates then constricts blood flow
Spreading the well-being
From nose to lips
Tongue to toes
Ready now
Start the day

Scroll
Click
Soft click depressions
E-mail tyranny
SPAM!
Moments of life fly by
Preparing to speak
Organized thoughts
In precise step-by-step
Procedure

Enter the room
From the back
Always
Unzip the file
Turn on the projector
Early Questions
Timid Freshman
Gentle Answers of encouragement

On a roll
Scattered laughter brings a smile
Plenty of time
Story time—illustrate the point
Get back to the point
What was the point?
Ah yes...
Out of time!

Where is the meeting?
Who will be there?
I need what?
Got it
Change the rules
Protect the turf
Work the Network!

Lunch
More Coffee
Jokes shared
Stories told
“I hear that...”
“Well I heard...”

In the lab
Each student needs personal time
Hours of dedication result in
Increased light
Comprehension in once blurred eyes
Even more coffee

Shades of Crimson orange
Blue
Purple and Grey
Paint the western sky in
Flecks of day-long memories
It's time for decaf

.....

*Anonymous, MSII-Class of 2008
Indiana University School of Medicine-Indianapolis*

“I struggled in gross anatomy, and I went to see Dr. Seifert after the first exam. He showed me a different way of learning. I studied by going through the lectures and just trying to reinforce the material in my head. He took the time to show me how to literally draw out the information so that I could make connections in the material. Going through that one lecture with him completely changed the way that I studied for not only Anatomy but all my courses. It took a lot of work, but I did better on the exams and passed the course.

At the end of the semester when I got my grade sheet from Anatomy, under comments the Anatomy professors wrote

something like, “This student performed satisfactorily in our course. She struggled a bit on our first two exams, but demonstrated to herself that she was capable by performing very well on our last exam. We wish her continued success in medical school.” Even though I “only passed”, I’m proud of my “P.” I worked really hard for it, and I really appreciate the fact the professors took the time to help me when I needed it most and then acknowledged my hard work after I succeeded in the course.”

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Crimson Waves

Anonymous, MSII-Class of 2008

Indiana University School of Medicine-Indianapolis

in a wave of fire,
the still breathe of life
blossoms and erupts
like 1000 guppies
jumping into the air
and riding the clouds like eagle

My experiences from the first year of medical school can be summed into one word – exhausting. The work load seemed overwhelming and left me frustrated. I even considered quitting medical school because I was disappointed with life as a medical student; it was not the rewarding experience I expected it to be. At a most difficult time when my passion for medicine seemed completely hidden by my negative attitude, I recalled an experience that helped me refocus and appreciate the opportunities I will have in medicine to truly make a difference in others’ lives.

As an undergraduate student, I volunteered at a cancer center where patients received radiation treatment. During their wait, I talked and listened to them, brought them blankets or snacks, or even offered a consoling hug. One afternoon, a very feeble lady specifically asked for apple juice. After spending twenty minutes searching for apple juice, I brought it to her. Despite her shaky fingers, she gripped my hand to show her appreciation.

However, it was what she said after that I will never forget – “You made a difference to me today.” She sounded so sincere and grateful. If showing care and compassion in the form of getting apple juice can make someone happy, just imagine what I can do as a practicing physician. Reflecting on this experience made me think that, yes, I truly do want to go into medicine. After this first year, I have come to realize that although such inspiring experiences are inseparable from negative experiences, it is those positive experiences that are more important and make it all worth while.

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Eight and One-half Medical Students

Maytee Boonyapredeedee, M.D., Class of 2005

Indiana University School of Medicine-Indianapolis

It is easy to forget the estrangement the patient feels when cared for in the hospital. The multitudes of physicians, nurses, physical therapists, pharmacists, students and other health care workers makes names and faces difficult to remember, and easier to ignore. If we take the time to know our pa-

tients and let them know us, then we may mitigate the stark contrast between home and hospital, bolster confidence and trust from the patient....

*"8½ Medical Students," Maytee Boonyapreddee
Oil on canvas*



The Ghost of Dr. Said*

Christopher Callahan, M.D.

Professor of Medicine

Indiana University School of Medicine-Indianapolis

I guess you would call it a nervous tic because it didn't seem to serve any useful purpose. From analyzing the rhythm of the movement, I can tell you that she had repeated it thousands of times. From head to toe she was fat and droopy in a cozy kind of way. She had the sort of lap that a kid or a cat would just naturally nestle into and fall asleep. Every few minutes she would flex her right elbow and, with a hooked right index finger, brush aside the collar of her blouse, snare her right bra strap, and yank the strap up and out while curling her shoulders and jostling her breasts. If a cat had been on her lap it wouldn't have awoken because the whole movement was as fluid and comforting as a deep breath. She smelled like baby powder but her clothes and hair were a little disheveled and grungy. She was about 60 or 70 years old. She had a big sack purse from which she pulled 10 or 12 empty medication bottles. Her physician had died recently and I was to replace him.

"How long has your shoulder been bothering you, Mrs. Platt?"

"Oh, I been sufferin' with that shoulder for years. Doctor said it can only be an infection or a cancer in the bone, and we know it ain't no infection 'cause it ain't never had no heat an' ain't never had no pus. Doctor said never to let no one cut on it though, 'cause'n if that cancer were let alone it would cure up on its own, but if'n you cut on it, it'll spread all over the body. Damn if he warn't right neither 'cause that's been 10 years ago and it ain't no worser and it don't cripple me none. Hell, my brother got cancer

in his bones and he was dead 6 months after they startin' cuttin' and foolin' with it".

"Do any of your other joints bother you?"

"Oh, sure, my hips and knees pain me so much I had to take to the stick but it don't really help none".

"What do you mean, 'take to the stick'?"

"A walkin' stick. A cane, you know. Doctor said I gots a cancer in them joints. One fool thought it was rheumatism and had me takin' aspirins but doctor said them aspirins make you bleed on the insides where no one can see it till yer dead. Sure enough they was tearin' me up too 'cause they put that hose in me and filled up my guts and found a hidin' hernia. Doctor said these pills would cut the acid". She held up an empty bottle. (There went the tic). She was out of breath after a string of two or three sentences.

"How long have you been having trouble with your breathing?"

"Oh, I've been sufferin' with emphysema for 5 year or more. Doctor said it probably come on me from livin' in the city. Been usin' some breathin' pills fer it and they been doin' all right by me".

"Do you smoke cigarettes?"

"Yep, I ain't gonna lie to ya, I lit up my first one when I was no more 'an 12. They don't seem to affect me none. Hell, my daddy smoked till he was 85 and they never done him no harm. I can take 'em or leave 'em myself but I never had no cause to stop. One time I gave 'em up and I got to shakin' and my heart was racing and skippin'. Doctor said it was on account of goin' cold turkey".

"Have you ever been hospitalized because of breathing difficulties?" "Never did need no hospital. I had a complete physical every year in the spring and doctor said I'm healthy as a horse.

Course I git antibiotics once or twiced a year for walkin' pneumonia but doctor said that was on account a me workin' in the weather. I need some antibiotics today 'cause I noticed some yeller when I spit this morning. Doctor said to take antibiotics whenever it turns yeller".

"What sort of trouble do you have with your heart?"

"Well, I built up some fat around the outsides of my heart that keeps its from pumpin' just so. Doctor said I'm damn lucky to be alive; said most others he's" (tic again) "seen with a case as bad as mine is dead and gone. Doctor said he caught it just in time. I'm takin' a heart pill and water pills and a pill fer nerves to keep my heart steady".

"You seem to be taking quite a number of medications, Mrs. Platt. Maybe we should spend some time today on straightening out your medical regimen".

"Ya, I need 'em all refilled 'cause I'm out".

"Well, that's what I would like to talk about, I'd like to change a couple of your medications and probably stop....".

As soon as she sensed my intentions, she edged forward in her chair and her droopy and cozy countenance perked up like the quills on a porcupine. I stopped in midsentence because I figured if I didn't let her vent immediately she would start firing off spines in my direction. (There went the tic, but this time the cat would have been flung to the floor in a heap.)

"Now you seem like a fine young doctor and I don't mine someone as young as you doctorin' on me 'ceptin if you're fixin' to fool with somethin' that ain't broke. Every time some new doctor tries to go messin' with my pills I end up a hackin' and wheezin' and painin'. I ain't had no trouble long as I'm takin' these here pills. Doctor said fer me ta stay on 'em fer good and by my way of thinkin', he'd know better what's good fer me and what ain't than someone

who's jus' laid eyes on me".

She held her fire to allow me a chance to surrender but I wasn't backin' down; who's the doctor here anyway? I prepared my face to resemble more closely my obvious experience with these matters and I stroked my mid-upper lip with a hooked right index finger. I silently outlined the first few sentences of my rebuttal: poly-pharmacy, ahem, ahem, data from recent clinical trials ahem, ahem, and so forth, and so on, and furthermore. Her quills began to prick up again. I hunched over the chart on my lap and began tapping my pen on it like a drum. Who was this old doc anyway and why should I refill all these medicines when they're probably not doin' much good? Cancer in the bone? Surely she misunderstood him. Why would she put so much faith in what this doctor said? How am I supposed to counter the assertions of some ghost authority whose colloquial explanations 10 years ago have been transformed by time into medical fact?

I pushed up my glasses and, rubbing my neck, continued my silent debate. I guess they're not really hurtin' any and she's been takin' 'em for years. I'm not sure what I would do differently anyway. 'Spect it wouldn't hurt ta go ahead and fill 'em this time. Hell, she made it this far, you can't argue with that; whatever the doctor said, she certainly believes whatever she thinks she heard him say. I pushed up my glasses and, tapping the chart, I responded diplomatically.

"You do seem to be getting along quite well, Mrs. Platt, and I certainly don't wanna rock the boat any. Maybe over the next few years," I said, pushing up my glasses and rubbing my chin, "if you're doing as well as you are now, you won't require quite so many different pills". "How bad's that cancer anyway?" she asked, as I began transcribing her numerous prescriptions.

"Well, strictly speaking, the problem with your shoulder is

probably due to degeneration of the joint space from wear and tear. What started out many years ago as a little discomfort and inflammation of minor severity has mushroomed into a severely damaged joint. We can treat your symptoms to some degree but we can't really do much to heal the damage incurred over the last 25 years".

"They still don't have a cure for cancer, do they, doc?"

"Uh, well, not for most cancers, no ma'am". I handed her the stack of prescriptions and she thumbed through them methodically.

"You forgot the antibiotic, I usually take ampicillin".

"Oh, sorry, that's right, here ya go," I replied lamely. She placed the prescriptions neatly in her handbag and left the room. Her companion greeted her as she departed and I heard him ask her what the doctor said.

"Same as the other'n, take the pills, they ain't got no cure. Doctor said that cancer in my shoulder's somethin' like a mushroom....".

*Reprinted with permission from *Annals of Internal Medicine* (1994), 120(2), 80-81.

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Bobby

Anna Edwards, MSII-Class of 2008

Indiana University School of Medicine-Lafayette

Bobby was an enormous man, weighing in at four hundred pounds, and embodied many characteristics of a caring physician. I first met Bobby at the homeless shelter where I would be living and working for a few months; he was going to be my "boss." I was in-

stantly enamored with his honesty and compassion. Perhaps he won my affection from his irresistible, toothless grin and the sparkle in his visionless eyes or perhaps he unknowingly filled the void of my deceased father.

As days passed, I saw that I was playing a similar role. His daughter, Shana, is mentally handicapped and will never be brave enough to go out into the world to chase her dreams. Bobby would never replace my mild-mannered dad, I would never replace Shana, yet we developed such an undeniably father and daughter-like relationship.

Whatever it was, we became practically inseparable. Bobby had been blind for some years, causing him to eventually lose his job, and then his family became homeless. These three equally large individuals lived in their Chevy Nova for a year until they found residence in the shelter. It was not long before Bobby won the respect of everyone around him and he became a coordinator at the shelter.

So, for just a few months, this loveable man and I were paired together to teach each other about human nature and the devastations that people face which lead them to homelessness. My day with Bobby typically began when he would call for me from his front porch; I would run to his side like a puppy to escort him to the dining room. I would rush around, bringing him his cereal and coffee, and he would update me on the phone calls he received during the night or the decisions that he made concerning some of the residents at the shelter. We would then head to the office, attempting to navigate this huge, blind, boat down a narrow sidewalk. Sometimes the sheer absurdity of this routine would send us into fits of giggles, while other times I shared in his frustration, and I would pray that I might give him my sight.

The days continued as we directed our attention to the residents struggling to help them progress towards independence and frustrated by their lack thereof. At first, it seemed insensitive to joke and giggle about some of the unique personalities we saw in the shelter.

I learned from Bobby that the best way he could deal with the impending heartbreak was to laugh first. I quickly learned to adopt his philosophy as I watched residents go back into the streets and pick up the habits that brought them to the shelter in the first place.

Bobby taught me how to work with the fringes of society along with skills that I hope to use with patients. As long as a doctor has deep compassion for his patients, laughter should be considered a blessing. What better way to cope with heartbreak than to see the humor of life? Bobby taught me that laughter allows room for compassion rather than closing doors and distancing myself to avoid inevitable hurt.

My work with Bobby soon ended and I headed for a backpacking trip through Europe. Before we said our tearful goodbyes, Bobby shoved a one hundred dollar bill into my hand and said that he wanted me to put it towards my education. I could not deny his extraordinary sacrifice and gesture of love so I vowed to put it to good use.

We talked on the phone a few times but by the time I got home, Bobby had died. I was heartbroken. So, when I think about Bobby, rather than focus on the rather large void he left, I imagine that winning toothless smile and his sparkling blind eyes. And I laugh.

Helping People Will Always be a Good Thing

Patrick Ockerse, MSI-Class of 2009

Indiana University School of Medicine-Indianapolis

While thinking about what I wanted to do with my life, it crossed my mind that I wanted to help people through medicine. Like most eager premed students I decided to learn about the medical field by volunteering and talking to many different physicians. Each one had their own stories and opinions, and I was inspired by most of them and their positive attitudes towards healthcare. There were, however, a few doctors that expressed certain dissatisfaction with the medical industry who made attempts to dissuade me from applying to medical school.

Their complaints were very similar involving insurance and politics interfering with their practices. The most common comment against the study of medicine was that “it is not what it used to be.” My hope is that these negative opinions were not the true feelings of these doctors, but only were representative of the immediate frustrations that they were dealing with. Regardless, these words were very disheartening.

A jaded physician is one I hope never to become. It is a wonder to me how someone with such a great opportunity to help people, and a great responsibility can ever become jaded. Though there are certain aspects in the field of medicine which may be considered unpleasant, I believe that these only show us where there is need for improvement. I see these complaints as a great opportunity to change those negative aspects of the healthcare system.

I think that with time, one can lose sight of the original attractions to the study of medicine. In a field where compassion is one of the most important qualities, becoming jaded can be the

greatest of downfalls. The best advice given to me before deciding to apply to medical school was from a doctor who said, "Some people will try to talk you out of becoming a doctor but not me. Helping people will always be a good thing." As I enter my first year of medical school, I hope that this advice keeps me from losing sight of why I chose medicine to study in the first place.

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Remembering

*Frances Brahma, M.A., M.L.S., Curriculum and Education Director, RLML
Competency Director for Lifelong Learning
Indiana University School of Medicine-Indianapolis*

Diagnosed with breast cancer
during my fourth year of medical school
almost a doctor
learning about healing
first-hand

will the doctor-turned-patient
be kinder and wiser
or will i soon forget
the person beneath the gown?
treat her with respect and kindness
while
looking at the evidence
looking into her eyes
and remembering.

*Anonymous, MSII-Class of 2008
Indiana University School of Medicine-Indianapolis*

“During my last annual gynecological exam my gynecologist found a lump in my left breast while performing her clinical exam. As her fingers paused to reexamine the area our conversation stopped and my heart sank. While she reassured me that the likelihood of the lump being cancer was extremely low, in the months thereafter fear sometimes overtook reason and the anxiety of not knowing was, at moments, overwhelming. I had follow-up appointments over the next six months, which included an ultrasound test. I made the decision to see a breast surgeon to have the lump removed so it could be examined by a pathologist to determine exactly what the lump was.

A week before my scheduled surgery, while working my summer job at the Methodist emergency department, I shadowed a resident as he visited a young female patient. During his physical exam, he found a lump in the woman’s breast that was extremely concerning to him. When he told the patient what he had found, she informed us that two years ago during a previous exam, her provider felt the same lump. The earlier doctor encouraged her to seek a follow-up, but she admitted that she had not taken his advice in fear of discovering it was cancer.

At first I hesitated, wondering whether it was appropriate to get so personal, especially since I was only a student bystander, but then I found myself beginning to speak. In a conversation lasting less than a minute, I told her about my parallel experience, and how the fear of not knowing could be consuming. I told her she owed it to herself to know what it was, either to quell her fears or to decide upon a plan of attack if necessary. I hope she takes the resident’s advice to follow up with further tests to heart, but I also hope she found someone she could relate to in me.”

D-5 Half-Normal*

William Tierney, M.D.

Professor of Medicine

Indiana University School of Medicine-Indianapolis

One of the most rewarding aspects of practicing medicine is the degree to which we can peek into the lives of persons very different and distant from ourselves, strangers who we would never encounter in such a personal way but for our vocation. At such times, the experience can be intensely meaningful. We all have such experiences. Occasionally, I have tried to capture the moment on paper...

The ringing of the telephone in a dark on-call room always startled me, even far into my internship (after I had stopped sleeping with my shoes on).

“Hello,” I answered dully, my heart pounding.

“Dr. Tierney?”

“Yeah.”

“I have an IV that needs re-starting.”

“Who?”

“24-B –Bridgewater.”

“The quad?”

“Yeah.”

My heart sank. Donny Bridgewater had a C6 transaction that he acquired in an automobile accident. His arms were of little use except as IV sites for treating his innumerable urinary tract infections and decubiti. Every house officer on campus has treated him at some time or another.

“What’s he getting?”

“D5 half-normal”

Hope! If he were only getting fluids, perhaps the IV could wait until morning!

“...and tobramycin.”

Groan! No way out. “Okay. I’m coming.” I kicked off my blanket, sat up, and pulled on my shoes. My roommate rolled over.

“Bilgewater?” [I always wondered if the cynical housestaff and students even recognized the reference to Huckleberry Finn.]

“Yeah.”

“Good luck.” He meant it.

The walk to the ward was punctuated by yawns. After picking up an IV tray at the nurse’s station, I walked to his room and turned on the grossly inadequate light, a single yellowed bulb at the head of his bed.

“Hi, Donny. I’m Dr. Tierney. I’m here to re-start your IV.”

He glanced up, lanced me with an expression that was a mixture of disdain and indifference, then closed his eyes and ignored me. As I cleaned his atrophic, contracted arm, I noticed a wire contraption attached to his hand. After a few moments, I realized that it must hold a pen or pencil. A look to his bedside tray-table revealed the pencil and a sheet of paper covered with barely legible scrawl:

Quiet and Cold
Spinning and stark
Old silent stinging

Stone and unyielding
Whispering orb
Blinding dark crescent

Metronomes dark
Been and begun
Withered and young
Wisdom unhurried
Refrains but unsung

Unending cord
Feeling and giving
Furrows, dead fields
Order in chaos
Taking, she yields

I was shaken. I could not reconcile his physical incapacity with the breadth of his vision and the depth of his feeling. Of the two of us, who was more handicapped? Whose mobility was more limited? Which one of us was mired in the mud? Whose numbness was greater? In a small, dark room amidst terror, hope, and pain, his angry spark of defiance and feeling had blinded me in my weary performance of routine tasks. I realized that I was a nameless, annoying, meaningless detail in his life.

Later, as I sat on my on-call bed and pulled off my shoes, my roommate rolled over again.

“Get it?”

“First stick.”

“Lucky.”

“Yeah.”

*Reprinted with permission from *SGIM Forum (1997), 20(1), 5 &7.*

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*Anonymous, MSIV-Class of 2006
Indiana University School of Medicine-Indianapolis*

“There was a patient I had while on general surgery who had been in the hospital for nine months. He had a lot of different problems. Part of my job every day was to go and walk this guy around. He had started to get better and had been refusing physical

therapy. I was supposed to walk him around the hall and walk him around the room, stuff like that. It wasn't a big deal but I just had to give him a little motivation. He and I got to talk and I got to do things that nobody else knows about. I got to talk with him about stuff that nobody else knows about and I got to pray with him. I didn't share this with my team, I didn't share it with anyone. It's the little things like that that I get to do with people every once in a while, it's not all the time, just every once in a while, and then I can say, you know, this is why I am here."

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Trifle

*Jeffrey Rothenberg, M.D., M.S.C.
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Indiana University School of Medicine-Indianapolis*



*Monica Mann, MSII-Class of 2008
Indiana University School of Medicine-Terre Haute*

“Now that I’ve been exposed to military training by doing the Officers Basic Course, I’m much more aware of the impact of being a nation at war for four years now... and how advancements in soldier armor and medicine are bringing many of our nations finest back alive.

The impact state-side is considerable too. I was able to visit the burn ward at Brooke Army Medical Center and see soldiers who left for Iraq with the mindset that they’d come back whole or in a box draped with Old Glory... and now they’re back and burned beyond recognition from explosives, and learning to live with that and take every day of rehab one at a time.

It’s painful to see, but you can also see the determination in their eyes, because many of them want to get *back* into the fight. These men are soldiers and it really gives me a new sense of patriotism, and purpose. I’ll most likely have the opportunity to work with (and on) some of them, and get them either back home to the US, or back on the front line defending the American way of life.

It’s very humbling, but very empowering at the same time. I know that I’ll make a difference in someone’s life, there’s really no getting around it. And then, when I’m back in the US and in a private practice, I’ll still know in my heart of hearts that I’ve achieved my own definition of success: making a difference, even if it’s just in one life.”

Dying Pretty

Larry Cripe, M.D.

Associate Professor of Hematology and Oncology

Indiana University School of Medicine-Indianapolis

The morning's first light slowly reveals the disarray on the bedside table. Ed's glasses rest on the crumpled cellophane next to a piece of uneaten cherry pie; a pocket Bible with an orange vinyl cover leans against a jaundice yellow emesis basin; the corner of a box of tissues protrudes from under a folded newspaper next to the phone; and a pitcher of water is set precariously close to the edge.

The fluorescent light over the sink softly illumines a blue polyester suit and a white shirt with a clip-on red tie hanging neatly from a hook on the closet door behind me. Ed's lifeless body lies partially covered with a sheet like a gnarled tree limb that has fallen into an irregular drift of snow. Karla—his first and fourth wife—rests her head on the pillow next to his, which is turned toward the window. A single shaft of sunlight cuts across their faces.

I had pronounced Ed dead several moments before and waited with Karla for her daughters to return from the cafeteria. Ed's question from yesterday afternoon as the admitting house officer and I examined him, "You didn't forget my suit did you? Show it to the doctors. Ain't it something doc?" echoes through my mind. The hospice chaplain had purchased the outfit for \$19.50 from the Goodwill Store with money donated by the hospice staff. Call it twenty dollars, I think as I glide my hand across the glossy smooth polyester of the lapel, not a bad price for some measure of peace for a dying man.

Thirteen weeks ago, I suggested to Ed that we consider hospice care. The lymphoma had recurred for a fourth time and there was no response to the most recent chemotherapy. It was doubtful that he would tolerate or benefit from further therapy. But Ed had a bully's instinct for ambivalence and he pushed back hard. Yes, I understood the news wasn't good news and his plans hadn't exactly included dying so soon.

But life isn't always what we plan. Yes, I remembered he had read in a pamphlet in my waiting room that his kind of cancer was the "curable" kind. But that doesn't mean everyone is cured. Yes, I was aware of the stories in the newspaper and magazines about new treatments for cancer. But the drugs aren't approved, the diseases are different, or the results are limited to laboratory experiments. He stormed out of the examination room. He could not imagine, I suspect, deliberately choosing a plan of care, the stated goal of which was improving the quality of remaining life. "What the hell is peaceful about that?" he said as he slammed the door.

Eight weeks before his death, Ed sat across from me barely making a dent in the cushion of the chair. The blunted pungency of stale tobacco smoke and unwashed clothes mixed with the sharp sweetness of alcohol on his breath seemed more substantial. Ed had seen an oncologist in a community practice and received chemotherapy since our last appointment. Karla had called my nurse every once in awhile. So I knew of the decision and the complications—including a week in the hospital—which he experienced. "No hard feelings," Ed said, as I walked into the examination room. I inquired how he was feeling, examined him briefly, and reviewed the most recent tests results with him. "Ed," I said, "I am not willing to continue the treatment. I am happy to care for you, but no more che-

motherapy.” Karla—a plump distracted woman with scraggly blondish hair and nicotine stained fingertips—rubbed the crude ink tattoo on her thick forearm and asked “What’ll happen if he don’t take more chemotherapy?” And then an ember of defiance flared amongst the ashes of resignation, “But hold on here. I haven’t said I don’t want no more treatment. I’m thinking. Doc ain’t the only one with an opinion. Right?”

“Absolutely. But I will not prescribe further chemotherapy.”

“What’ll happen? How’s it going to be the dying and all?” Karla persisted.

“Ugly. Just like I lived. I imagine it’ll be ugly,” Ed said shaking his head.

There is no polite way to summarize Ed’s life. He drank heavily from a young age. Sober or drunk, he had little regard for the welfare of wife, children, and family. He was never gainfully employed for longer than several months. The clinic nurses immediately pegged him for an abusive husband and father. Ed’s attempts at charm—he thought himself a character—were heavy-handed and unsuccessful.

They cared for him generously, but maintained a respectful distance. And he developed the cowering and potentially menacing demeanor of a stray mongrel around them. On the other hand, our interactions had a casual permissiveness; he was, on some level, a character.

His stories did capture an entertaining irreverence for and indifference to the rather narrow and staid limits of life lived more conventionally. Isn’t that the appeal of dark humor? Nonetheless, I agreed with his use of the word ugly. Ed finally broke the silence. “I never pegged you for a quitter doc. What good is all that education for if you’re quitting on me?” And I

silently agreed that it did feel like I was quitting. I explained that we would focus on how he felt, his symptoms. I would not hesitate to prescribe medicines to relieve his symptoms and to allow him to live as well as possible for as long as possible. “But at some point the lymphoma will progress and your body will fail. We will care for you as your life ends; the goal is a peaceful death for you and your family,” I said. Ed stared at me incredulous.

“Alright. I’m not promising nothing. I’ll meet with the hospice,” Ed said, “And if I sign up I’ll see you each week. But I just might go see my other cancer doctor. Just being straight with you.” I assured Ed that I could work through the hospice nurses. He did not need to burden his family or himself with weekly visits. Honestly, I discouraged Ed because there were no tests to interpret, chemotherapy to administer, side effects to manage, or further decisions to make. What would we accomplish? But he insisted and we saw each other weekly until the afternoon he was admitted to the hospital for intravenous narcotics and died the following morning.

Ed brought a dog-eared manila folder of articles ripped from magazines and newspapers to the next visit. “Let me know what you think about this,” he said. For a while, he began subsequent visits by asking, “What did you think? Anything we can try? Did you know about that? Did you call anyone about that?”

During the visit three weeks before he died, Ed did not mention the manila folder. He didn’t want to answer a bunch of questions or be poked at. He wanted to talk; he told Karla to wait for him outside. Ed had concerns. His sons from his various marriages would not visit. Karla’s daughters were encouraging her to leave him. They said she did not owe him anymore, that he had sucked her dry enough already. Was he going to be

alone? What was his funeral going to be like? Would anyone come? Maybe it would be better if no one came because he didn't want a bunch of people staring at him all skinny and pale and dead. Who would be there to say something nice about him?

"There's things I done that I ought not to have done. I know that," he said, "but there's no call for the girls to be this way. Karla and me go way back; lot of water under that bridge," he said.

"Ed, have you met the hospice chaplain?" I asked.

"He calls asking to come to the house. Never had much use for religion, doc. Not likely much point in starting this late," he sighed. Then he began telling stories about his life, none of which were pleasant. Ed spoke with an unexpected and unadorned directness, his usual air of grievance absent. In the twenty minutes or so—astonished I remained silent—Ed became less diminished and more distinct as a person. He was Ed—weaker, thinner, and less confrontational; he was not a character.

"Ed a chaplain is better able to ...", I began to say as we left the room together.

"You're doing just fine doc. See you next week."

We met twice more in my office. The manila folder was never mentioned; he, Karla and I discussed his decline and what to expect.

I did share our conversation with the chaplain. I know he and Ed met several times before Ed died. I do not know what Ed spoke about with the chaplain. Was there contrition? Was there forgiveness? I saw no evidence of reconciliation with his sons or Karla's daughters. I do know this: Ed confided to the chaplain that it bothered him greatly that he did not own a decent suit to be buried in. The chaplain collected donations from

the hospice staff and bought a suit. It hung in Ed's room at home, in plain view, until the night Karla brought it to the hospital with him.

When I first met Ed several years ago he was quite ill. As we discussed the diagnosis, the proposed treatment, and the possible outcomes with treatment, I said, "The goal is to cure the disease."

"I like that just fine," he said barely able to speak.

"But I cannot guarantee that. The disease may not respond, or you may not tolerate the side effects."

"I'm tougher than I look," Ed replied, "You do your best and I'll be just fine."

The initial response to treatment was nothing short of miraculous. The massive swelling in his lymph nodes and abdomen subsided and he gained weight. There were no complications of therapy. And then, after a few years, the disease recurred. The response to subsequent treatments was less definite and the toll of treatment greater; Ed rarely felt well. Nonetheless, it must have been, on some level, inconceivable to him that he would die based upon his initial experience and the information about medical advances he read in the lay press and patient advocacy publications. I am (fairly) certain Ed would have agreed to receive chemotherapy—had my opinion changed—even the day he was admitted. Perhaps he initially returned weekly in hopes of changing my mind.

Whatever his reasons, it occurs to me, as I watch Karla smooth the hair back from his ashen face, that Ed's weekly visits were a gift. I am disappointed how frequently I find myself advising the individuals for whom I care to forgo further chemotherapy, to focus on the quality of the life remaining. I believe that the only way Ed could convince himself that I was not quit-

ting, when I refused to prescribe further chemotherapy, was by seeing me weekly. And that taught me something about not quitting. Not quitting, especially as life ends, is to remain present and to witness—perhaps to foster—the discovery of the so-called little things that matter most.

There was one final gift. Last night, as I was preparing to leave his hospital room, Ed beckoned me to lean my ear close to his mouth—with a final imperious gesture—and whispered, “Ain’t it something doc? I’m dying pretty.”

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Chandler Summer

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